DEPARTMENT	OF HEALTH	AND HUMAN	SERVICES
CENTERS FOR	MEDICARE	& MEDICAID	SERVICES

AND PLAN OF CORRECTION DENTIFICATION NUMBER: 155780	DATE SURVEY
NAME OF PROVIDER OR SUPPLIER MADISON HEALTH CARE CENTER, LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A Life Safety Code Recertification and K0000 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 7465 MADISON AVENUE INDIANAPOLIS, IN46227 (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE	COMPLETED
NAME OF PROVIDER OR SUPPLIER MADISON HEALTH CARE CENTER, LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A Life Safety Code Recertification and K0000 This plan of correction is to	/26/2011
MADISON HEALTH CARE CENTER, LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A Life Safety Code Recertification and K0000 This plan of correction is to	
MADISON HEALTH CARE CENTER, LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A Life Safety Code Recertification and K0000 INDIANAPOLIS, IN46227 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE K0000 A Life Safety Code Recertification and K0000 This plan of correction is to	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A Life Safety Code Recertification and K0000 This plan of correction is to	
PREFIX TAG A Life Safety Code Recertification and (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) A Life Safety Code Recertification and K0000 This plan of correction is to	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A Life Safety Code Recertification and K0000 This plan of correction is to	(X5)
K0000 A Life Safety Code Recertification and K0000 This plan of correction is to	COMPLETION
A Life Safety Code Recertification and K0000 This plan of correction is to	DATE
and a Madis and Hardy Hardy	
and a Madis and Hardy Hardy	
Serve as Madison Health Care	
State Licensure Survey was conducted by	
the Indiana State Department of Health in Center's credible allegation of	
accordance with 42 CFR 483.70(a).	
Submission of this plan of	
Survey Date: 08/26/11 correction does not constitute	
an admission by Madison	
Facility Number: 012225 Health Care Center or it's management company that the	
Provider Number: 155780 allegations contained in the	
AIM Number: 200983560 survey report are a true and	
accurate portrayal of the	
Surveyor: Mark Caraher, Life Safety provision of nursing care and	
other convices in this facility	
Code Specialist Nor does this submission	
constitute an agreement or	
At this Life Safety Code survey, Madison admission of the survey	
Health Care Center, LLC was found not in allegations.	
compliance with Requirements for	
Participation in Medicare/Medicaid, 42	
CFR Subpart 483.70(a), Life Safety from	
Fire and the 2000 edition of the National	
Fire Protection Association (NFPA) 101,	
Life Safety Code (LSC), Chapter 19,	
Existing Health Care Occupancies and	
410 IAC 16.2.	
This one story facility was determined to	
be of Type III (200) construction and fully	
sprinklered. The facility has a fire alarm	
system with smoke detection in the	
corridors and all areas not separated from	
the corridor. The facility has a capacity of	
130 and had a census of 64 at the time of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RBCE21

Facility ID:

012225

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED	
		155780	B. WING		08/26/2011	
		II.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	L.		IADISON AVENUE		
MADISO	N HEALTH CARE C	CENTER, LLC	I	IAPOLIS, IN46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	this visit.					
	Code Specialist-Me The facility was	Robert Booher, Life Safety dical Surveyor on 09/01/11. found not in compliance entioned regulatory evidenced by the				
K0029 SS=E	fire-rated doors) of extinguishing system and/or 19.3.5.4 pm. When the approve extinguishing system are separated from resisting partitions self-closing and not protective plates the from the bottom of 19.3.2.1 1. Based on obsetthe facility failed serving hazardous mechanical room storage rooms grage feet in size used materials are each closing devices of to automatically into the door frampractice could af	d construction (with ¾ hour of an approved automatic fire em in accordance with 8.4.1 otects hazardous areas. Sed automatic fire em option is used, the areas of other spaces by smoke and doors. Doors are con-rated or field-applied that do not exceed 48 inches of the door are permitted. Between the door are permitted. Between the state of the doors are such as the of the laundry and the state of the door are than fifty square to store combustible the equipped with self on the entry door in order close and latch the door me. This deficient of the mechanical room the state of the mechanical room in the entry the mechanical room	K0029	K029 – It is the practice of Madison Health Care Center ensure that doors with self-closing devices are used protect hazardous areas. I. a The door to the mechanical r by laundry and the door to the central supply room were corrected by the maintenanc supervisor. b. The trash ca that were greater than 32 ga were removed from the building. II. All residents hav potential to be affected. This being addressed by the systematical statematics.	d to a. coom lie e ns Illons re the s is	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RBCE21 Facility ID: 012225

If continuation sheet Page 2 of 19

PRINTED: 09/14/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155780		A. BUIL	DING	NSTRUCTION 01 ———	(X3) DATE S COMPLI 08/26/2 (ETED	
	PROVIDER OR SUPPLIER		B. WINC	STREET A	DDRESS, CITY, STATE, ZIP CODE ADISON AVENUE APOLIS, IN46227	30,20,20	
	SUMMARY S (EACH DEFICIENT REGULATORY OR by the laundry ar room. Findings include a. Based on obset Operations Direct facility from 12:108/26/11, the me laundry contains water heaters and equipped with a sequipped with a sequipped with a sequipped with a sequipped with the laundry is not closing device or b. Based on obset Operations Direct facility from 12:108/26/11, the Cermeasures 100 squ store disposable as well as other of supplies and the equipped with a sequipped with	EENTER, LLC TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Ind the Central Supply Evolution with the Plant stor during a tour of the 15 p.m. to 2:55 p.m. on chanical room by the three natural gas fired If the entry door is not self closing device. Evolution with the Plant of Plant Operations Director of emechanical room by the equipped with a self of the entry room door. The evolution with the Plant of tor during a tour of the 15 p.m. to 2:55 p.m. on ontral Supply room user feet and is used to briefs in cardboard boxes combustible nursing entry room door is not self closing device.		7465 M	ADISON AVENUE	not rs ns for e coors tive lits	(X5) COMPLETION DATE
	equipped with a sentry door.	self closing device on the					

012225

PRINTED: 09/14/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155780	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 01	(X3) DATE COMPL 08/26/2	ETED
	PROVIDER OR SUPPLIER			7465 M	DDRESS, CITY, STATE, ZIP CODE ADISON AVENUE APOLIS, IN46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	the facility failed where trash colle greater than 32 g feet were being s separated from or resisting partition provided with an system. LSC 19 collection rooms automatic closing practice could affect visitor in the vicil entrance corridor. Findings include Based on observ Operations Direct facility from 12: 08/26/11, two 16 (119.7 gallons pecarts were filled were unattended other in the corrientrance. The trawere not being strom other space partitions and do interview at the terms of the sing strom other space partitions and do interview at the terms of the sing strom other space partitions and do interview at the terms of the sing strom other space partitions and do interview at the terms of the sing strom other space partitions and do interview at the strong service of the sing strong s						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RBCE21 Facility ID:

ID: 012225

If continuation sheet

Page 4 of 19

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155780		A. BUILI	DING	O1	(X3) DATE S COMPL 08/26/2	ETED	
	PROVIDER OR SUPPLIER		B. WING	STREET AD	DDRESS, CITY, STATE, ZIP CODE DISON AVENUE POLIS, IN46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
K0045 SS=E	outside trash bin employee entrangused to store trast gallon capacity. 3.1-19(b) Illumination of medischarge, is arrarsingle lighting fixtuarea in darkness, emergency lighting 7.8.) 19.2.8 Based on observation facility failed to of 8 exit means of the failure of any (bulb) would not darkness. This daffect any staff of the facility from Findings include Based on observation facility from 12:: 08/26/11, the exit the employee exilight fixture with interview at the temployee and the facility from 12:: 08/26/11, the exit the employee exilight fixture with interview at the temployee and the facility from 12:: 08/26/11, the exit the employee exilight fixture with interview at the temployee and the facility from 12:: 08/26/11, the exit the employee exilight fixture with interview at the temployee and the facility fixture with interview at the temployee exilight fixture with interview at the temployee exiliging fixture with the temployee exili	eficient practice could r visitor if needing to exit the employee exit.	K00)45	K045 It is the practice of Machealth Care Center to have illumination at means of egrethat will not leave the area in darkness.I. The maintenance supervisor will replace the existing light fixture at the employee entrance so it will two bulbs instead of one. II. residents have the potential taffected. This is being addressed by the systems described below. III. The maintenance supervisor will inspect all exit light fixtures of quarterly basis for proper woorder. IV. The affected area be added to the preventative maintenance program for re-inspection on a quarterly basis. The results of the audiare reported to the facility's quality assurance committee additional recommendations	ss e nave All o be n a rking will	09/25/2011

PRINTED: 09/14/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155780		(X2) MULTIPI A. BUILDING B. WING	0	PUCTION	(X3) DATE S COMPL 08/26/20	ETED	
MADISO	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7465 MADISON AVENUE INDIANAPOLIS, IN46227				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	C	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
K0046	provided at the example of the examp	ture with one bulb was mployee exit. g of at least 1½ hour		n	ecessary.		
SS=C	duration is provided 19.2.9.1. Based on observation interview; the fact testing of emerged accordance with battery operated 7.9.3, Periodic To Lighting Equipment test to be conducted and an annual test every required be emergency lighting than 1 ½-hour dube fully operation test. Written record and tests shall be inspection by the jurisdiction. This affect all occupation including staff, verification.	ation, record review and cility failed to document ency lighting in LSC 7.9 for 2 of 2 emergency lights. LSC esting of Emergency lent, requires a functional ted at 30 day intervals at to be conducted on attery powered and system for not less tration. Equipment shall hal for the duration of the bords of visual inspections kept by the owner for authority having a deficient practice could hats in the facility isitors and residents.	K0046	Hoeel billing signal	GO46 It is the practice of Macdealth Care Center to do test of the emergency lighting equipment. I. The facility has pattery operated emergency ghts. The maintenance supervisor was unable to find focumentation from the monor annual inspections. A more annual inspections. A more appearance of the completed september 25, 2011. II. All esidents have the potential the esidents of the systems described below the systems described below the systems described below the esident of the esident operated emergency ghts. IV. The affected area are added to the preventative maintenance program for esinspection on a monthly an annual basis. The results of sudits are reported to the fact quality assurance committee diditional recommendations becessary.	ting s two d thly nthly by I so be essed nthly will d the dility's for	09/25/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RBCE21 Facility ID:

012225

If continuation sheet

Page 6 of 19

PRINTED: 09/14/2011 FORM APPROVED OMB NO. 0938-0391

l	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155780	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE COMP 08/26/2	LETED
	PROVIDER OR SUPPLIER		7465 M	ADDRESS, CITY, STATE, ZIP CODE ADISON AVENUE APOLIS, IN46227	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
	facility from 12: 08/26/11, there a emergency lights One battery oper outside emergency second battery of the emergency per room inside the freview with the I from 9:30 a.m. to documentation of functional testing least a 1 ½-hour battery operated available for reviat the time of recoperated emergency monthly basis but no documentation					

012225

STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155780			(X2) M A. BUII		ONSTRUCTION 01	(X3) DATE COMPI	LETED
		155780	B. WIN	G		08/26/2	011
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7465 MADISON AVENUE INDIANAPOLIS, IN46227				
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
K0050 SS=F	Fire drills are held varying conditions, shift. The staff is f is aware that drills routine. Responsi conducting drills is competent persons exercise leadership conducted betwee announcement manualible alarms. 1. Based on recount facility failed drills on the third thi	at unexpected times under at least quarterly on each samiliar with procedures and are part of established bility for planning and assigned only to so who are qualified to p. Where drills are in 9 PM and 6 AM a coded by be used instead of 19.7.1.2 and review and interview, to conduct quarterly fire it shift for 1 of 4 quarters. In actice affects all facility including and visitors. The of "Record of Drills" with the Plant Operations and a.m. to 11:35 a.m. on an odocumentation of a conducted on the third shift arter of 2010. Based on time of record review, the Director acknowledged umentation of a third the fourth quarter of 2010.	K	0050	K050 It is the practice of Madison He Care Center to have fire drills a quarterly on each shift and have transmission of the fire alarm si I. 1. The facility was in compli with fire drill during the time frecited. During this time frame the facility had 12 hour shifts so we had two shifts per day instead of three. Three fire drills were performed in this quarter. 2. The documentation of the alarm signal could not be found maintenance supervisor. II. All residents have the potent be affected. This is being address by the systems described below. III. The maintenance supervisor continue to conduct fire drill quarterly on each shift. All fire will have documentation of the transmission of the fire alarm signal could fire drill quarterly on each shift.	t least e gnal. ance ame ne e only f fire by tial to essed f r will drills	09/25/2011
	the facility failed				IV. The fire drill audits are rep	orted	
					l		

PRINTED: 09/14/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155780	(X2) MULTI A. BUILDIN B. WING		01	(X3) DATE S COMPL 08/26/20	ETED
	PROVIDER OR SUPPLIER		S1 74	465 M <i>A</i>	DDRESS, CITY, STATE, ZIP CODE ADISON AVENUE APOLIS, IN46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
IAG	transmission of to of 2 fire drills cop.m. on the first sand for 2 of 2 fire 9:00 p.m. on the quarters. LSC 19 health care occup transmission of the simulation of em. This deficient proccupants in the residents, staff and Findings include. Based on review documentation with Director from 9:30 p.m. and on and documentation fire drills conduct p.m. and on 5/23 include the transmissional. Based on record review, the Director stated the activated for each acknowledged do second shift fire 9:00 p.m. in the fire of the process of t	the fire alarm signal for 2 inducted prior to 9:00 shift for 2 of 4 quarters are drills conducted prior to second shift for 2 of 4 (2.7.1.2 states fire drills in pancies shall include the the fire alarm signal and ergency fire conditions. The actice affects all facility including and visitors. The plant Operations and the plant Operations are the first onducted on 01/26/11 at an 04/27/11 at 10:40 a.m. on for two second shift at the one of the fire alarm are interview at the time of the Plant Operations are fire alarm system was an fire drill but becumentation of first and drills conducted prior to first and second quarter include transmission of			to the facility's quality assurance committee monthly for addition recommendations and to ensure continued compliance.	al	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RBCE21 Facility ID:

ty ID: 012225

If continuation sheet

Page 9 of 19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155780		(X2) MUL A. BUILD B. WING		O1	(X3) DATE S COMPLI 08/26/20	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7465 MADISON AVENUE INDIANAPOLIS, IN46227				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0051 SS=F	according to NFPA Code, to provide e any part of the buil complete fire alarm alarm initiation, au extinguishing syste in patient sleeping provided that man 200 feet of nurse's located in the path written records of reliable second so Fire alarm systems accordance with N maintenance are k is remote annuncia system to an appro 19.3.4, 9.6 Based on observa facility failed to e Communicator T telephone dialer(alarm system wo within 4 minutes and be annunciat LSC Section 9.6. station notificatio with NFPA 72 Na NFPA Section 5- A DACT shall en following combin channels:	tes or equipment is installed a 72, National Fire Alarm ffective warning of fire in Iding. Activation of the in system is by manual fire tomatic detection or item operation. Pull stations areas may be omitted ual pull stations are within stations. Pull stations are of egress. Electronic or itests are available. A surce of power is provided. If a readily available. There is are maintained in IFPA 72 and records of itest readily available. There is ation of the fire alarm oved central station. Attion and interview, the itemsure the Digital Alarm ransmitter (DACT) is for the facility's fire is for the facility's fire is for the facility is fire in a supervisory station in the in accordance in to be in accordance actional Fire Alarm Code. 5.3.2.1.6.1 states:	K00	951	K51 It is the practice of Madison Heroman Care Center to have a digital alacommunicator transmitter (DAC telephone dialers for the fire alasystem. I. An outside contractor came to facility on 9-8-11 and repaired system so telephone lines report trouble. II. All residents have the potent be affected. This is being addres by the systems described below III. During the monthly fire dress the maintenance supervisor will	orm or the tail to ssed rills	09/25/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RBCE21 Facility ID:

012225 If continuation sheet Page 10 of 19

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLET	
		155780	B. WIN	IG		08/26/201	1
NAME OF	PROVIDER OR SUPPLIEI	R	-		ADDRESS, CITY, STATE, ZIP CODE	-	
MADIOC	AN LIEALTH CARE	DENTED II O			ADOLIO INACCOZ		
MADISC	N HEALTH CARE (INDIAN	APOLIS, IN46227		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE C	COMPLETION
TAG			+	TAG	ensure that the (DACT) telepho	ana l	DATE
	1 ' '	ne line (number) and one			dialers for the facility's fire alar		
	cellular telephor				system will send a trouble signa		
	1 ` ′	ne line (number) and a			within 4 minutes to our supervis		
	one-way radio sy	•			station (SafeCare) and be		
	1 ` ′	ne line (number) equipped			annunciated locally when disab	led.	
	with a derived lo				IV. The fire drill audits are rep	orted	
	1	ne line (number) and a			to the facility's quality assurance		
	one-way private radio alarm system				committee monthly for addition		
		ne line (number) and a			recommendations and to ensure	;	
	1 ^	private microwave radio system			continued compliance.		
	(7) One telephone line (number) and a two-way RF multiplex system						
	1 ` '	tegrated services digital					
	` ′	telephone line using a					
	terminal adapter	specifically listed for					
	supervising stati	on fire alarm service,					
	where the path b	between the transmitter					
	and the switched	l telephone network					
	serving central c	office is monitored for					
	integrity so that	the occurrence of an					
	adverse conditio	n in the path shall be					
	annunciated at the	he supervising station					
	within 200 secon	nds.					
	NFPA at 5-5.3.2	.1.6.2 states the following					
	requirements sha	all apply to all					
	combinations in	5-5.3.2.1.6.1:					
	(1) Both channe	els shall be supervised in a					
	manner approve	d for the means of					
	transmission em	ployed.					
	(2) Both channe	els shall be tested at					
	intervals not exc	eeding 24 hours.					
	Exception No. 1	: For public cellular					
	1 ^	e, a verification (test)					
	1 -	ransmitted at least					

AND PLAN OF CORRECTION IDE		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155780	A. BUII	DING	ONSTRUCTION 01	(X3) DATE : COMPL 08/26/2	ETED
NAME OF PROVIDER OR SUPPLIER MADISON HEALTH CARE CENTER, LLC			B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE ADISON AVENUE APOLIS, IN46227	1 ** *	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	lines (numbers) a permitted to test (number) at alter (3) The failure of send a trouble sign within 4 minutes (4) When one trafailed, all status of sent over the other exception: Where with a DACT, and shall not be requisignals other than adverse condition line (number). (5) The primary of delivering an interest that the message supervising station (6) The first attent change signal shall channel. Exception: Where known to have face (7) Simultaneous channels shall be (8) Failure of tellocally. This deficient pragations are the statement of the control of tellocally. This deficient pragatical is a service of the control of the co	change signals shall be er channel. The used in combination derived local channel ared to send status change in those indicating that has exist on the telephone channel shall be capable andication to the DACT has been received by the bon. In the send a status and use the primary The telephone is transmission over both a permitted. The shall be annunciated is shall be annunciated					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	nstruction 01	(X3) DATE SURVEY COMPLETED
		155780	A. BUILDING B. WING		08/26/2011
NAME OF I	PROVIDER OR SUPPLIER		l	DDRESS, CITY, STATE, ZIP CODE ADISON AVENUE	
MADISO	N HEALTH CARE C	ENTER, LLC	I	APOLIS, IN46227	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
	Findings include				
	Operations Direct facility from 2:10 08/26/11, when to telephone line was 2:10 p.m. to 2:20 alarm system fail signal to a supervito annunciate a transparent observation, the last ted the facility monitoring computrouble signal who telephone line was acknowledged the	ation with the Plant for during a tour of the D p.m. to 2:20 p.m. on he DACT primary as disconnected from p.m. the facility's fire led to send a trouble visory station and failed rouble signal locally. ew at the time of Plant Operations Director or's fire alarm system cany did not receive a men the DACT primary as disconnected and also the fire alarm system failed rouble signal locally.			
	3.1-19(b)				
K0075 SS=E	not exceed 32 gal average density of room or space doe (20.4 L/sq m). A c not exceeded with area. Mobile soile receptacles with ca gal (121 L) are loc	sh collection receptacles do (121 L) in capacity. The f container capacity in a es not exceed .5 gal/sq ft capacity of 32 gal (121 L) is in any 64 sq ft (5.9-sq m) d linen or trash collection apacities greater than 32 ated in a room protected as when not attended.			
		ation and interview, the ensure a capacity of 32	K0075	K 075	09/25/2011
	_	le soiled linen or trash		It is the practice of Madison He Care Center not to use trash or	I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155780		IDENTIFICATION NUMBER:	A. BUIL	DING	01			
155760			B. WING			08/26/2	011	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
MADISO	N HEALTH CARE C	CENTER LLC	7465 MADISON AVENUE INDIANAPOLIS, IN46227					
					7 (1 OE10, 11440227		(115)	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX CR		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	*	LSC IDENTIFYING INFORMATION)			CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE	
	collection recept	acles was not exceeded			containers greater than 32 gallo	ns in		
	within any 64 sq	uare feet area in 1 of 10			any hazardous area when not			
		leficient practice could			attended.			
		nt, staff or visitor in the			I. The two trash containers wer	e		
	vicinity of the en	nployee entrance			removed from the facility.			
	corridor.							
					II. All residents have the poten			
	Findings include	:			be affected. This is being addressed by the systems described below.			
					by the systems described below	•		
	Based on observa	ation with the Plant			III. The maintenance superviso			
	Operations Direc	etor during a tour of the			validated that no other containe	rs in		
	facility from 12:15 p.m. to 2:55 p.m. on		the facility are greater than 32 gallons. The administrator reviewed			ewed		
		cubic feet capacity						
		er each cart) mobile trash			be			
		with combustible trash,	responsibility for making future					
		and stored next to each			purchases of containers. The	form		
		dor by the employee		maintenance supervisor will perform a monthly hazard inspection of the facility.				
		on an interview at the						
		on, the Plant Operations						
		ne trash carts were			IV. The monthly hazard inspective will continue to be done monthly			
		rt to the outside trash bin			The audits are reported to the	у.		
		ed the employee entrance			facility's quality assurance			
		ng used to store trash			committee monthly for addition			
	carts of greater tr	nan 32 gallon capacity.			recommendations and to ensure			
	3.1-19(b)				continued compliance.			
	J.1-17(U)							
17.01.4.4	Conorators are in	spected weekly and						
K0144 SS=F		spected weekly and bad for 30 minutes per						
55-1	month in accordar							
	3.4.4.1.				12.4.4.4.14.15.415	-U	00/2 - /- 01/	
	1. Based on obse	ervation and interview,	K0	144	K 144 It is the practice of Ma	aison	09/25/2011	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155780 08/26/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7465 MADISON AVENUE MADISON HEALTH CARE CENTER, LLC INDIANAPOLIS, IN46227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Health Care Center for the the facility failed to ensure 1 of 1 generator to operate in emergency generators was equipped with accordance with regulation. I. 1. a remote manual stop. NFPA 99, Health The facility does not have a Care Facilities, 3-4.1.1.4 requires remote starter for the generator. A bid was obtained from an generator sets installed as alternate power outside contractor to install a sources shall meet the requirements of remote started. By 9-15-11 an NFPA 110, Standard for Emergency approval will be received from Standby Power Systems. NFPA 110, corporate office for capital 3-5.5.6 requires Level II installations shall expenditure. The remote started will be installed by an outside have a remote manual stop station of a contractor by 9-25-11. 2. The type similar to a break glass station facility was able to find the written located outside of the room where the documentation of the weekly prime mover is located. This deficient inspections of the starting batteries for the emergency practice could affect all residents, staff generator. 3. The facility is and visitors. unable to perform a monthly load test greater than 30%. To meet this requirement the facility has Findings include: received a bid for an outside contractor to perform a load bank Based on observation with the Plant test. By 9-15-11 an approval will Operations Director during a tour of the be received from corporate office facility from 12:15 p.m. to 2:55 p.m. on for capital expenditure. The load bank test will be completed by an 08/26/11, no evidence of a remote shut off outside contractor by 9-25-11. II. device was found for the 80 kilowatt All residents have the potential to natural gas fired emergency generator be affected. This is being which had a manufacture date listed on addressed by the systems described below. III. 1. The facility the emergency generator label of October will have an outside contractor 2003. Based on interview at the time of test the remote starter on an observation, the Plant Operations Director annual basis. 2. The facility will acknowledged there is no remote continue to perform weekly inspection of the starting batteries emergency shut off for the emergency for the emergency generator. generator. This will be added to the preventative maintenance 3.1-19(b) program. 3. An outside contractor will do a load bank test on an

Facility ID:

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
				LDING	01	08/26/2	
		100700	B. WIN		DDDEGG CITY CTATE ZID CODE	00/20/2	011
NAME OF I	PROVIDER OR SUPPLIEI	₹		1	ADDRESS, CITY, STATE, ZIP CODE ADISON AVENUE		
MADISON HEALTH CARE CENTER, LLC				1	APOLIS, IN46227		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	annual basis. IV. The weekly		DATE
		ord review and interview,			audits of the emergency		
	1	d to ensure a complete			generator and the annual		
		f weekly inspections of			inspections from the outside		
	_	eries for the emergency			contractor are reported to the	9	
	"	aintained for 12 of 52			facility's quality assurance committee monthly for addition	nnal	
	1 ^	3-4.4.1.3 of NFPA 99			recommendations and to ens		
	requires storage				continued compliance.		
		essential electrical					
	1 -	inspected at intervals of					
	not more than 7 days and shall be maintained in full compliance with						
		pecifications. Defective					
		e repaired or replaced					
	1	on discovery of defects.					
		FPA 110, 6-3.6 requires					
		e batteries, including					
	1 -	s, at intervals of not more					
	1	apter 3-5.4.2 of NFPA 99					
	_	n record of inspection,					
	1 *	ercising period, and					
		enerator to be regularly					
		available by the authority					
	1	on. This deficient					
	1 ^	fect all residents, staff					
	and visitors. Findings include:						
	Based on review	of "Generator Load					
	Testing Log She	et: Weekly Exercise"					
	1	vith the Plant Operations					
		record review from 9:30					
	_	n. on 08/26/11, weekly					
		rator records for the forty					

∥ '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155780		LDING	NSTRUCTION 01	(X3) DATE COMPL	ETED
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				7465 M	ADISON AVENUE		
MADISO	N HEALTH CARE (INDIAN	APOLIS, IN46227		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	week period from 11/16/10 through 08/23/11 was maintained, but no						
		of weekly starting battery to 11/16/10 was					
		iew. Based on interview					
		cord review, the Plant					
		ctor stated the facility					
	1 *	in May 2010, weekly					
	1 - 1	ons for the emergency					
	1 * *	t start until 11/16/10, and					
	~	veekly battery inspections					
	1) is not available for					
	review.						
	3.1-19(b)						
	3 Rased on reco	ord review and interview,					
		d to ensure a monthly load					
	1	nergency generators was					
	conducted using						
	1	ds: under operating					
	1	ditions, at not less than					
	1 ^	rgency Power Supply					
		e rating, or loading that					
	1 ' ' -	nimum exhaust gas					
	temperatures as	recommended by the					
	manufacturer. C	Chapter 3-4.4.1.1 of NFPA					
	99 requires mon	thly testing of generators					
	serving the emer	gency electrical system to					
	be in accordance	with NFPA 110. Chapter					
	6-4.2 of NFPA 1	10 requires generator sets					
	in Level 1 and L	evel 2 service to be					
	exercised at leas	t once monthly, for a					
	minimum of 30	minutes, using one of the					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 01	COMPL	ETED	
		155780	B. WIN			08/26/2	U11
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
MADISON HEALTH CARE CENTER, LLC				1	ADOLIS INACCO		
					APOLIS, IN46227		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG			COMPLETION DATE
IAG		· · · · · · · · · · · · · · · · · · ·	+	IAU	Dia relative 17		DATE
	following method	ng temperature conditions					
	1 *	U 1					
		n 30 percent of the EPS					
	nameplate rating						
		naintains the minimum					
	exhaust gas temp						
	l *	the manufacturer.					
		e of day for required					
	~	ecided by the owner,					
		operations. This					
	deficient practice						
	residents, staff ar	10 VISITORS.					
	Findings include	:					
	Based on review	of "Generator Load					
	Testing Log Shee	et: Weekly Exercise"					
	documentation w	ith the Plant Operations					
	Director during r	record review from 9:30					
	a.m. to 11:35 a.m	n. on 08/26/11, the					
	emergency gener	rator ran on a monthly					
	basis for at least thirty minutes each						
	1	riod of 11/16/10 through					
	07/26/11 but the	minimum exhaust gas					
		operating temperature are					
	not recorded, how	wever, the percentage of					
	load capacity wa	s recorded as 6% for each					
	month. Based or	n interview at the time of					
	record review, th	e Plant Operations					
	Director stated th	ne minimum exhaust gas					
	temperature and	operating temperature are					
	not recorded and	acknowledged the					
	percentage of loa	d capacity recorded was					
	less than 30 perc	ent of the EPS nameplate					

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 01 COMPLETE				
		155780	B. WING		08/26/2011	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			IADISON AVENUE		
MADISOI		CENTED II C	I			
MADISOI	N HEALTH CARE C	DENTER, LLC	INDIAN	IAPOLIS, IN46227		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	rating.					
	C					
	3.1-19(b)					
	3.1-19(0)					